THE MARKET FOR HEALTH CARE SERVICES

Spending for health care increased from 6.1 percent of gross national product (GNP) in 1965 to 10.6 percent of GNP in 1984. Part of this increase in resources spent on health care represented improvements in access to and quality of care, the first resulting from wider availability of health insurance coverage and the second from advances in the practice of medicine. At the same time, however, widespread health insurance coverage may have caused expenditures to rise faster than warranted by improvements in care. 12/

The market for health care is unusual for at least two reasons: the prevalence of third-party payment through insurance, and the dual role of physicians as both health care advisers and providers. As explained below, patients have incentives to demand services whose potential benefits are less than the costs of providing them, while most physicians (those paid on a fee-for-service basis) have incentives to encourage patients to obtain all services of any potential net benefit. As a result, from a social point of view, too much may be spent for health care at the expense of other important needs unless third-party payers implement mechanisms to control health care spending.

Patients' Behavior in an Insured Market

When bills are paid by a third party, patients have weaker financial incentives to restrict the price and volume of services than when patients bear full financial responsibility. Income permitting, patients will generally purchase additional health services so long as the anticipated benefits (net of any inconvenience and risk involved) exceed their out-of-pocket costs. Because out-of-pocket costs are less than charges when patients have insurance coverage, insured patients are more likely than uninsured patients to expand their demand for services to include those with small expected benefits. At the extreme, patients whose insurance policies do not require cost-sharing will seek services so long as there is any net expected benefit, no matter how small. Insured patients make more office visits and may submit to more diagnostic tests and therapeutic procedures than they would

12. About 85 percent of all people, and 99 percent of people age 65 or older, had some insurance coverage during the fourth quarter of 1983, based on data from the Survey of Income and Program Participation, which is conducted regularly by the Bureau of the Census.

if they paid all of the resulting charges. 13/ Further, they may be less likely than uninsured patients to shop for a better price on services, since only part of any resulting savings would accrue to them.

Patients' demands for services will expand even when patients as a group pay the full costs of insurance coverage through premiums. This expansion occurs because most patients respond to out-of-pocket costs--the effective price they face at the time of service--without concern for the higher insurance premiums they might be charged in later years because of increased use of services by the insured population. There is even more reason for expansion in patients' demand for services when the insured population--like the Medicare population--does not pay the full cost of insurance through premiums. In this case, purchasing power is transferred to Medicare enrollees from taxpayers who subsidize the Medicare program. 14/

The purpose of health insurance is to transform the large and unpredictable costs that individuals may face for medical care into a moderate and predictable expense, by pooling the risks across a suitably large population. The resulting protection is highly desirable, but an inevitable accompaniment to insurance coverage is a reduction in incentives for the insured population to purchase covered services prudently.

Physicians' Behavior

Physicians can and do influence their patients' use of medical services. Such influence is considered to be an important part of the physician's job, as the patient's agent in areas where the patient is not well informed. When serving as an agent or adviser for patients, a physician is expected to suggest any services that could be of benefit to the patient, allowing the patient to decide whether the expected net benefits, as explained by the physician, are large enough to justify the associated out-of-pocket costs. Considerable un-

13. See Joseph P. Newhouse and others, "Some Interim Results from a Controlled Trial of Cost-Sharing in Health Insurance," *New England Journal of Medicine*, vol. 305, no. 25 (December 17, 1981), pp. 1501-1507; and K.N. Lohr and others, "Effect of Cost-Sharing on Medical Care Episodes and Episode Size" (paper presented at the 113th Annual Meeting of the American Public Health Association, Washington, D.C., November 1985).

14. Medicare enrollees' benefits are subsidized in two ways. Most enrollees in the Hospital Insurance program paid payroll taxes during their working years to establish their eligibility for benefits, but the current value of taxes paid is far below the insurance value of current benefits. Enrollees in the voluntary Supplementary Medical Insurance program pay premiums to establish their eligibility for benefits, but premiums cover only 25 percent of benefits, and the remainder is paid from general revenues.

certainty exists in the practice of medicine, however, and thus suggested treatment for a given set of presenting symptoms may differ widely among physicians. One factor that may sometimes influence physicians' treatment patterns in the face of uncertainty about appropriate care is the financial incentives they face.

A concern is that physicians may sometimes respond to economic pressures that would otherwise reduce revenues from their practices by attempting to induce patients to consume additional medical services whose expected benefits would be small. As a result, events that might be expected to reduce health care costs--such as fee constraints, or a growing supply of physicians relative to the population, or increased cost-sharing that reduced patient visits--could be at least partially offset by physician-induced increases in the volume of services. 15/

One general model of physicians' behavior might be that physicians seek to establish an optimal mix of income, leisure, and professional satisfaction. If their current equilibrium were disrupted by, for example, a fee freeze that reduced their real incomes (because costs increased while practice revenues were unchanged under current practice patterns), physicians would make adjustments in an attempt to recover some portion of the loss in real income. Physicians might, for example, work more hours (reducing leisure) by accepting more patients or suggesting more follow-up visits for established patients. Another adjustment might be to bill for more services or for more complex services than they would have previously (perhaps reducing professional satisfaction). This latter adjustment could be accomplished in two ways: by "unbundling" services, billing separately for services such as laboratory tests that physicians had previously provided without charge as part of an office visit; or by "code creep," providing more complex (and more highly reimbursed) services than physicians would previously have considered as adequate treatment. 16/

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15. See Gail R. Wilensky and Louis F. Rossiter, "The Relative Importance of Physician-induced Demand in the Demand for Medical Care," *Milbank Memorial Fund Quarterly*, vol. 61, no. 2 (Spring 1983), pp. 252-277, for evidence that physician density has a significant, but small, effect on increasing physician-induced demand for services. See Marianne Fahs, "Physician Response to Cost Sharing: The Other Side of the Coin" (paper presented at the 113th Annual Meeting of the American Public Health Association, Washington, D. C., November 1985), for evidence that, when patients faced with higher cost-sharing cut down on their number of visits, physicians respond by inducing the patients they see to use more services.

16. Note in particular that one need not assume that physicians alter their practice patterns in whatever way necessary to maintain some preset "target income" in order to explain demand-inducement by physicians.

Evidence from a number of "natural" experiments during the 1970s--in California, Colorado, and Quebec--indicates that physicians tend to respond to fee constraints by increasing the number and complexity of services for which they bill. 17/ The clearest evidence comes from state Medicaid program data where patients' copayments were small fixed amounts per encounter, so that changes in approved reimbursement rates had no effect on patient behavior. Studies of the California Medicaid program in the mid-1970s show that physicians billed for increasingly more complex (and thus more costly) services per encounter with Medicaid patients during a period of several years when Medicaid payment rates were declining in real terms, but that average complexity per encounter fell the year that Medicaid payment rates were increased. 18/

Some people have suggested that the scope for volume responses may be more limited now than in the 1970s, because of heightened competition in the health care sector and increased demand by both insurers and patients for cost-conscious care. Experience with the fee freeze in the SMI program (discussed above) appears to indicate, however, that there is still scope for volume increases by physicians in response to fee constraints.

Insurers' Behavior

The onus is on insurers to design mechanisms to control both charges for and the use of health care services since, as discussed above, neither patients nor physicians have incentives to use medical services prudently in an insured fee-for-service market.

Cost-sharing is widely used by insurers to limit patients' overuse of services, and it effectively reduces the number of episodes of care initiated by patients. Once an episode of care has been initiated by a patient, though, cost-sharing apparently has little or no effect in limiting the volume or cost

17. For a review of studies on this subject, see Jon R. Gabel and Thomas H. Rice, "Reducing Public Expenditures for Physician Services: The Price of Paying Less," *Journal of Health Politics, Policy, and Law*, vol. 9, no. 4 (Winter 1985), pp. 595-609.

18. See John Holahan, Margaret Sulvetta, and William Scanlon, "Medicaid Fee Controls and Physician Behavior: Preliminary Evidence from California," Working Paper No. 1250-03 (Urban Institute, Washington, D.C., 1981). See also Philip J. Held, John Holahan, and Cathy Carlson, "The Effects of Medicaid and Private Fees on Physician Participation in California's Medicaid Program, 1974-1978," Working Paper No. 1306-02-01 (Urban Institute, Washington, D.C., 1983).

of services provided (or ordered) by physicians. 19/ Further, there is evidence that when a significant portion of a physician's patients faces increased cost-sharing, the resulting reduction in visits by those patients induces the physician to increase fees and the volume of services provided to patients who do present themselves for care. 20/

Consequently, controls by insurers on physicians and other health care providers appear to be important to contain costs effectively when care is provided on a fee-for-service basis. Constraints on fees alone are at best only partially effective at restraining costs, since physicians are able to respond to limits on the prices they charge for services by increasing or upgrading the services for which they bill. Utilization controls appear to be necessary in the fee-for-service sector to limit the ability of physicians to increase the volume of services for which they bill, in response either to fee constraints or to a low patient load. Alternatively, incentives to limit the volume of services could be created by replacing fee-for-service reimbursement with payments for more comprehensive service packages, such as fixed prepayments for all care provided a patient in a given period of time, commonly called capitated payments.

19. Lohr and others, "Effect of Cost-Sharing on Medical Care and Episode Size."

20. Fahs, "Physician Response to Cost Sharing."

CHAPTER II

CURRENT METHODS OF REIMBURSING PHYSICIANS UNDER MEDICARE

Medicare currently pays for physicians' services in two ways--either on a fee-for-service basis or on a capitation basis. In the fee-for-service system, Medicare pays physicians or their employers for each service provided to Medicare enrollees. In the capitation system, Medicare pays a fixed amount per enrollee to a prepaid medical plan (PMP) that agrees in turn to provide all covered services required by enrollees during a specified period of time. 1/

More than 95 percent of Medicare enrollees receive care in the fee-for-service sector, and Medicare's payment methods in this sector are the focus of this chapter. As the result of provisions in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Medicare enrollment in PMPs may grow to be similar to the share for the nonaged population, which is currently about 9 percent (but increasing rapidly). 2/ Unless enrollment in PMPs is made mandatory for receipt of Medicare benefits, though, there will likely always be a substantial proportion of Medicare enrollees who prefer to receive care in the fee-for-service sector, so that the issue of changes in fee-for-service payment methods will remain.

Medicare sets payment rates for physicians' services in the fee-for-service sector using the customary, prevailing, and reasonable (CPR) system. 3/ In 1984, about 85 percent of allowed amounts under the CPR system was paid to physicians. The remainder was paid to limited license practitioners (such as psychologists or podiatrists), to independent labora-

1. Prepaid medical plans include both health maintenance organizations and other competitive medical plans.

2. Enrollment under TEFRA was delayed, because implementing regulations were not published until January 1985.

3. This is called the usual, customary, and reasonable (UCR) method by private insurance companies that use it.

tories, or to suppliers of medical equipment and ambulance services (see Table 3). This study focuses on payments to physicians.

About 35 percent of Medicare payments for physicians' services were made to generalists--general or family practitioners and internists. About 36 percent of payments was to surgical specialists, 14 percent was to non-surgical specialists, and another 14 percent was to supporting physicians in

TABLE 3. ALLOWED AMOUNTS FOR CPR CLAIMS, BY TYPE OF PROVIDER, 1984

Type of Provider	Allowed Amounts		Percent for Inpatient Services
	In Millions of Dollars	As a Percent of Total	
Physicians	17,326.8	85.0	59.0
Limited License Practitioners a/	797.8	3.9	10.2
Laboratories	362.7	1.8	1.0
Medical Suppliers b/	1,896.8	9.3	0.8
All Providers c/	20,384.0	100.0	50.6

SOURCE: Congressional Budget Office tabulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Procedure file.

NOTE: CPR = customary, prevailing, and reasonable system.

a. Includes psychology, podiatry, optometry, audiology, chiropractic, dentistry, and physical therapy.

b. Includes suppliers of medical equipment, prosthetics, and ambulance services.

c. Total does not include charges for hospital outpatient department facility fees or for risk-based prepaid medical plans, since these are not reimbursed through the CPR system.

radiology, anesthesiology, and pathology. Less than 1 percent of payments went to osteopathic physicians. Services to hospital inpatients accounted for 59 percent of Medicare's allowed amounts for physicians' services, although this share varied considerably by physician specialty (see Table 4). Physicians' inpatient services are already subject to some constraints that arise indirectly from the effects (discussed later) of the prospective payment system on hospitals.

TABLE 4. ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES, BY PHYSICIAN SPECIALTY, 1984

Specialty	Allowed Amounts		Percent for Inpatient Services
	In Millions of Dollars	As a Percent of Total	
Generalists a/	6,012.7	34.7	47.7
Nonsurgical Specialists b/	2,476.4	14.3	60.4
Surgical Specialists c/	6,271.4	36.2	66.6
Radiologists	1,453.3	8.4	51.0
Anesthesiologists	833.3	4.8	93.4
Pathologists	164.3	0.9	72.2
Osteopaths	115.4	0.7	30.8
All Physicians	17,326.8	100.0	59.0

SOURCE: Congressional Budget Office tabulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Procedure file.

a. Includes general practice, family practice, internal medicine, pediatrics, and clinics.

b. Includes allergy, cardiology, dermatology, gastroenterology, nephrology, neurology, physical medicine, psychiatry, and pulmonary disease.

c. Includes general surgery, otolaryngology, neurosurgery, gynecology, ophthalmology, orthopedic surgery, plastic surgery, colon and rectal surgery, thoracic surgery, and urology.

Nearly 75 percent of allowed amounts to physicians were for medical care, medical consultations, or surgery. Diagnostic laboratory tests billed by physicians accounted for more than 7 percent of allowed amounts, and diagnostic radiology accounted for another 9 percent (see Table 5). The proportion of physicians' charges that were for laboratory tests should be lower in subsequent years, because physicians may no longer bill Medicare for tests done outside the office; instead, laboratories performing the tests must bill Medicare directly.

TABLE 5. ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES, BY TYPE OF SERVICE, 1984

Specialty	Allowed Amounts		Percent for Inpatient Services
	In Millions of Dollars	As a Percent of Total	
Medical Care	6,315.3	36.4	49.3
Surgery	5,888.1	34.0	75.9
Assistance at Surgery	314.8	1.8	89.2
Anesthesia	840.3	4.8	94.2
Diagnostic Laboratory Tests	1,240.8	7.2	26.6
Diagnostic Radiology	1,578.5	9.1	44.3
Therapeutic Radiology	235.1	1.4	18.6
Consultations a/	621.6	3.6	77.6
Other b/	292.3	1.7	2.2
All Services	17,326.8	100.0	59.0

SOURCE: Congressional Budget Office tabulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Procedure file.

a. Includes first and second opinions for surgery.

b. Includes treatment for renal patients, pneumococcal vaccine, and medical supplies, among other things.

HOW THE CPR SYSTEM WORKS

This section discusses four basic elements of the CPR system: how the unit of payment is defined, how payment rates are set, what requirements for assignment are specified, and what controls on volume are imposed.

Unit of Payment

The unit of payment under the CPR system is the service--including visits, consultations, and procedures. About 7,500 different services are recognized for payment purposes under HCFA's Common Procedure Coding System (HCPCS), including not only physicians' services but also codes for supplies or services provided by nonphysicians. HCPCS, which is based on the American Medical Association's Current Procedural Terminology (CPT-4) system, was adopted by Medicare in 1982 as the common system to be used for all SMI claims. Conversion to HCPCS was completed in July 1985. Before that time, a uniform coding system had not been used in all regions to identify the SMI services billed to and paid by Medicare.

Payment Rates

Under the CPR system, Medicare's approved charge for each physician's service is set at the lowest of four alternative rates: 4/

- Physician's submitted charge--the billed amount;
- Physician's customary charge--defined as the physician's median charge for that service during the previous year;
- "Unadjusted" prevailing charge for that service in the locality--defined as the 75th percentile of the distribution of customary charges for all physicians in the locality; or
- "Adjusted" prevailing charge--defined as the prevailing charge applicable in June 1973 inflated by an index of earnings and office expenses called the Medicare Economic Index (MEI).

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4. A number of terms are used interchangeably to refer to Medicare's payment rates, including "reasonable charge," "approved charge," "approved amount," and "allowed amount." Ordinarily, Medicare's payments (either to physicians or their patients) would be allowed amounts less deductible and coinsurance amounts paid by enrollees. Under the provisions of the Balanced Budget and Emergency Deficit Control Act of 1985, however, Medicare's payments will be reduced by 1 percent during the period from March 1, 1986, through the remainder of the fiscal year. This reduction does not affect the determination of allowed amounts.

Medicare's approved rates are less than submitted charges for nearly 85 percent of physicians' services billed, because of the effects of the customary and prevailing fees or "screens." In 1984, about 15 percent of allowed amounts was equal to physicians' submitted charges, while 30 percent was reduced by customary screens and 55 percent was reduced by prevailing screens (see Table 6).

The adjusted prevailing screen was added by legislation enacted in 1972 as a device to slow the growth in SMI costs. Since physicians' actual charges have typically increased at a faster rate than the MEI, the proportion of approved charges with payment set by MEI-adjusted prevailing fees has been increasing over the years. If the CPR system is continued, the proportion of charges set by adjusted prevailing fees will continue to grow, though slowly. CBO estimates that by fiscal year 1991, under current law, about 72 percent of Medicare's approved charges will be set by prevailing fees, and that 56 percent of charges will be set by MEI-adjusted prevailing fees. 5/ The relationship between payment rates for services whose rates are set by adjusted prevailing fees is the same as the relationship between prevailing fees in 1973. These rates, in turn, were set by physicians' actual charges during calendar year 1971.

In principle, Medicare may modify payment rates based on customary and prevailing fees when they are not "inherently reasonable"--in comparison with payment rates for the same services for non-Medicare patients, for example, or using information about the costs of providing the services. To date, only very limited use has been made of inherently reasonable criteria to override the charges based on customary and prevailing fees, but the Health Care Financing Administration has proposed to make more aggressive use of this provision to reduce rates. 6/

Medicare's approved rates vary by geographic location and, in most payment localities, by specialty. Medicare contracts with private insurance companies (called carriers) to administer payments to physicians, including calculation of approved rates and payment of claims. In 1984, there were 56 Medicare carriers and 240 payment localities. 7/ Most carriers (all but six)

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5. These projections use the current MEI. If the MEI were rebased as proposed by the Administration in its 1987 budget, the percent of charges set by prevailing fees would be slightly higher (see Chapter III).

6. Transmittal 1115, dated August 1985. See also the proposed rule published in the *Federal Register*, vol. 51, no. 32 (February 18, 1986), p. 5726.

7. In addition, there are regional carriers that administer SMI reimbursements for Railroad Retirement beneficiaries.

TABLE 6. PERCENT OF PHYSICIANS' ALLOWED AMOUNTS AND BILLS CONSTRAINED BY ALTERNATIVE FEE SCREENS, 1984

Physician Practices by Specialty and Location	Fee Screen Used to Set Payment			Fee Screen Used to Set Payment		
	Billed Amount	Customary Screen	Prevailing Screen a/	Billed Amount	Customary Screen	Prevailing Screen a/
	Percent of Allowed Amounts			Percent of Services Billed		
All Practices b/	14.5	30.4	55.1	17.4	31.4	51.2
Generalists						
General practice	23.6	27.8	48.6	22.0	26.7	51.3
Family practice	19.3	27.7	53.0	18.7	24.4	56.9
Internal medicine	15.5	29.7	54.8	15.4	27.4	57.2
Specialists						
Nonsurgical c/	17.3	37.3	45.4	18.1	38.0	43.9
Surgical d/	10.7	29.3	60.0	16.6	39.4	44.0
All Practices by Location						
Nonmetropolitan	19.5	23.3	57.2	19.8	19.3	60.9
Metropolitan	13.7	31.4	54.9	16.8	34.3	48.9

SOURCE: Congressional Budget Office tabulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

a. Includes the unadjusted prevailing, the adjusted prevailing, and lower ceilings set by "inherently reasonable" criteria or by HCFA regulations. HCFA regulations specify that payment rates for certain medical and radiology services rendered in hospitals not exceed specified percentages of the prevailing fees for those services when rendered in physicians' offices. Further, clinical laboratory fees are set by fee schedules.

b. Includes claims submitted for the 258 top-ranked services (based on total allowed amounts) for all physicians in the sample except pediatricians, psychiatrists, osteopaths, radiologists, anesthesiologists, and pathologists. Data from 15 of the 56 Medicare carriers were excluded because of various reporting problems. The excluded carriers were for Georgia, Iowa, Michigan, eastern Missouri, Montana, New Jersey, eastern New York (the New York City area), North and South Carolina, North and South Dakota, Texas, Utah, Puerto Rico, and the Virgin Islands.

c. Includes allergy, cardiology, dermatology, gastroenterology, nephrology, neurology, physical medicine, and pulmonary disease.

d. Includes general surgery, otolaryngology, neurosurgery, gynecology, ophthalmology, orthopedic surgery, plastic surgery, colon and rectal surgery, thoracic surgery, and urology.

establish specialty-specific prevailing rates for each service. Carriers are free to set whatever criteria they choose to define specialties for payment purposes, including board certification, board eligibility, or self-designation by physicians. The latter, however, is used almost exclusively. 8/

Assignment

Since October 1, 1984, Medicare has had a "participating physician" program, under which participating physicians agree on a year-to-year basis to accept assignment on all Medicare claims. Nonparticipating physicians may accept or reject assignment on a claim-by-claim basis, as all physicians treating Medicare patients did before the participating physician program was introduced. As incentives to participate, the Deficit Reduction Act of 1984 (DEFRA) provided for periodic publication of lists of participating physicians and electronic claims processing for them. In addition, physicians who did not sign participating agreements were prohibited from increasing their billed amounts for Medicare during the period of a fee freeze imposed on all physicians under DEFRA. 9/ About 30 percent of physicians who treat Medicare patients signed participating agreements for fiscal year 1985, and 28 percent signed agreements for fiscal year 1986.

Assignment rates on Medicare's SMI claims have never dropped below 50 percent, and they increased slowly from their nadir in the mid-1970s through 1983. Assignment rates increased from 50.5 percent in 1976 to 53.9 percent in 1983, although the average reduction by Medicare on billed amounts grew from 19.5 percent to 23.2 percent (see Table 7). 10/ Most analysts attribute the increase in Medicare's assignment rates through 1983

8. Ira Burney and others, "Medicare Physician Payment, Participation, and Reform," *Health Affairs* (Winter 1984), pp. 6-24.

9. All physicians--both participating and nonparticipating--were subject to a freeze on Medicare's payment rates in effect from July 1, 1984, until May 1, 1986 (or January 1, 1987, for nonparticipating physicians). Participating physicians, however, were permitted to increase actual charges (or billed amounts), while nonparticipating physicians were not. An increase in actual charges by participating physicians could have no effect on Medicare enrollees' liabilities or physicians' Medicare receipts during the freeze because of assignment, but under the CPR system it would result in an increase in Medicare's payment rates for these physicians when the freeze was lifted.

10. Alma McMillan, James Lubitz, and Marilyn Newton, "Trends in Physician Assignment Rates for Medicare Services, 1968-1985," *Health Care Financing Review*, vol. 7, no. 2 (Winter 1985).

TABLE 7. MEDICARE PART B ASSIGNMENT RATES BASED ON SMI CLAIMS AND CHARGES, AND PERCENT REDUCTION ON SUBMITTED CHARGES, 1968-1985

Calendar Year	Basis for Assignment Rates		Percent Reduction on Submitted Charges
	Claims	Charges	
1968	59.0	--	--
1969	61.5	--	--
1970	60.8	--	--
1971	58.5	53.8	11.4
1972	54.9	50.3	11.2
1973	52.7	48.1	12.2
1974	51.9	47.8	14.4
1975	51.8	47.7	17.4
1976	50.5	47.6	19.5
1977	50.5	48.2	19.0
1978	50.6	49.6	19.3
1979	51.3	50.7	20.8
1980	51.5	51.7	22.4
1981	52.3	53.0	23.5
1982	53.0	54.2	23.7
1983	53.9	55.6	23.2
1984	59.0	59.6	24.9
1985	68.5	68.6	26.9

SOURCE: Health Care Financing Administration, Bureau of Quality Control. Reprinted from Alma McMillan, James Lubitz, and Marilyn Newton, "Trends in Physician Assignment Rates for Medicare Services, 1968-1985," *Health Care Financing Review*, vol. 7, no. 2 (Winter 1985).

to greater competitive pressures on physicians, because of the growing number of physicians relative to the population. This effect has apparently been large enough to offset the reduction in assignment rates that would otherwise have resulted from the decline in Medicare's payment rates relative to physicians' submitted charges. 11/

11. See Lynn Paringer, "Medicare Assignment Rates of Physicians: Their Responses to Changes in Reimbursement Policy," *Health Care Financing Review*, vol. 1, no. 3 (Winter 1980), pp. 75-89.

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Assignment rates jumped dramatically following implementation of the participating physician program in 1984. For the first quarter of calendar year 1985, the assignment rate was 68.5 percent overall--63.9 percent for physicians and 82.5 percent for suppliers. The average assignment rate for participating physicians was 100 percent, of course, while the average rate for nonparticipating physicians was 43.5 percent. 12/

Controls on Volume

Although Medicare carriers have long been expected to conduct some utilization review to detect fraudulent claims, until recently there were no formal guidelines or requirements for carriers to follow. Beginning in 1984, however, Medicare carriers were required to institute prepayment screens to detect fraudulent, erroneous, or excessive claims for seven common services, expanded to 16 services effective November 1985 (see Table 8). Further, by fiscal year 1987, HCFA hopes to develop formal guidelines for carriers' postpayment utilization review activities in order to improve their effectiveness at identifying physicians whose practice patterns indicate chronic overprovision of services.

In addition, some controls on the volume of physicians' services operate indirectly through the prospective payment system. Peer Review Organizations (PROs) seek to eliminate unnecessary hospital admissions, and hospitals have financial incentives under the PPS to minimize lengths of stay for patients who are admitted. As a result, some physicians' services are being shifted to ambulatory settings, while others may be eliminated. The potential for these hospital-focused efforts to control Medicare's costs for physicians' services is substantial, because nearly 60 percent of Medicare's approved charges for physicians are for inpatient services. 13/

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12. Health Care Financing Administration, Bureau of Quality Control, "Report on Medicare Participating Physician/Supplier Claim Workloads, January-March 1985." Separate assignment rates for physicians and nonphysicians are not available for prior years. The Deficit Reduction Act of 1984 contained a provision that made assignment mandatory for independent laboratories--one of the nonphysician providers billing under Medicare Part B.

13. CBO tabulations from HCFA's 1984 Medicare Annual Data Procedure file.

TABLE 8. PREPAYMENT SCREENS FOR SMI REIMBURSEMENT

Type of Claim	Screen
Routine Foot Care (Except acute surgery and mycotic nails)	Every 60 days
Joint Injections	3 per month
Mycotic Nails	1 treatment per 60 days
Nursing Home Visits	1 per month
B-12 Injections	1 per month based on diagnosis
Comprehensive Visit, New Patient	1 per carrier history (16 to 27 months)
Holter Monitoring	1 per 6 months
Chiropractic (Spinal manipulation)	12 per year
Concurrent Care (Inpatient)	Different practitioner, same or similar specialty, sees patient same day
Hospital Visits	31 per month; 31 per 3 months
Comprehensive Visit, Established Patient	1 per 6 months
Skilled Nursing Facility (Subsequent care, brief visit)	2 first week, 1 per week thereafter
Injections (All except B-12, joint, allergy, chemotherapy)	24 per year
Urological Supplies (Indwelling catheters)	2 per month
Postcataract Replacement of Contact Lens	1 per eye per year
Assistants at Cataract Surgery a/	None at routine surgery

SOURCE: Congressional Budget Office from information provided by the Health Care Financing Administration.

NOTE: Effective November 1, 1985, Medicare carriers were required to use these prepayment screens, which are intended to trigger medical review, not automatic denial, of claims exceeding the screens.

a. Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, no payment will be made for assistants at cataract surgery unless prior approval by the carrier has been obtained.